WIC Program Referral Form
(Women)

Please enter below all the data available. This will expedite the establishment of an appointment for determining WIC program eligibility.

A. **Applicant's Name**: _____ Date of birth: _____ SS# _____

Date of referral to WIC _____ . Person making referral: _____ Agency _____

B. **Screening Data**:

PREGNANT WOMEN (measurements and lab test data must be no more than 60 days old at the time of the eligibility screening)

Date of measurements:	Height in inches (no shoes):	Weight in pounds & ounces:	Date test done:	Hgb. or Hct.:
EDC:	**Prepregnant weight:**	**Date last pregnancy ended:**	**Number of pregnancies including this one:**	**Hx. poor pregnancy outcome(s)? If yes, dates:**

POST PARTUM WOMEN:

Date of measurements:	Height in inches (no shoes):	Weight in pounds & ounces:	Date test done:	Hgb. or Hct.:
Date this pregnancy ended:	**Number of live births including this one:**	**Hx. poor pregnancy outcome(s)? If yes, dates:**	**This pregnancy only: Multiple birth: 2, 3, 4, 5 Infant(s) condition:**	

C. **Diagnosed Nutrition Related Problems** (check all that apply):

_Anemia
_Nutrient deficiency disease (specify) _____
_Gastrointestinal disorder (specify) _____
_Diabetes mellitus
_Gestational diabetes
_Thyroid disorder (specify) _____
_Chronic hypertension
_Renal disease (specify) _____
_Cancer (specify) _____
_CNS disorder (specify) _____
_Genetic or congenital disorders (specify) _____
_HIV or AIDS
_Recent major surgery (specify) _____
_Food allergy (specify) _____
_Lactose intolerance
_Hx. of preterm infant (date) _____
_Hx. of low birth weight infant (date) _____
_Hx. of infant birth with defect (specify) _____
_Fetal growth restriction
_Pica (specify) _____
_Maternal Depression (specify) _____
_Alcohol or illegal drug use (specify) _____
_Prescribed medication (specify) _____
_Smoking (amount/day) _____
_Other nutrition related health problems (specify) _____

_____ Date: _____
Signature of referring medical professional